Special Articles and Association Notes

The Manitoba Medical Association Review

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Membership in the Manitoba Medical Association

Statements of the annual dues have been sent to members of the Manitoba Medical Association. Application forms have also been forwarded to those who have not been members or whose membership has lapsed. For the convenience of those paying their dues a cheque form is attached and also a stamped and addressed reply envelope. The collection of dues, like other office routine, involves some expenditure of funds and an early response will help to reduce this expense.

Those who are to be away or for any other reason do not wish to join the Manitoba Medical Association this year are asked to co-operate by filling out the "Alternative Reply Form" and returning it in the envelope provided. This will avoid the forwarding of another statement.

The Executive Committee have attempted to make the payment of the annual dues as convenient as possible for the members, and ask for the co-operation of the profession.

ANNUAL MEETING

Visiting Speakers

The Canadian Medical Association are arranging for two speakers, in addition to the President and the General Secretary, to attend the Annual Meeting of the Manitoba Medical Association in September. The names of the visitors will be announced at an early date.

Scientific Programme

Members of the Manitoba Medical Association are invited to submit papers for the scientific programme of the annual meeting in September, 1939. Those wishing to deliver papers should forward copies or an abstract. Applications will be received up to May 1st. The selection will be made by the Scientific Programme Committee.

Suggestions from members as to particular subjects which they would wish to have discussed are also invited.

Communications may be sent to the Honorary Secretary, Manitoba Medical Association, 102 Medical Arts Building, Winnipeg. They will be sent on to the Committee for consideration and action.

FACULTY OF MEDICINE

University of Manitoba

Post Graduate Course in Paediatrics

February 14, 15 and 16, 1939

All clinics will be held at the Children's Hospital, except that from 11.00 to 12.00 on the first day, which will be on East 1 at the General Hospital.

All the sessions of this course will be illustrated by clinical cases.

The Children's Hospital is located on Main Street at Aberdeen Avenue, one block south of Redwood Avenue.

The visiting clinician will be Dr. Joseph Brennemann, Chief of Staff of the Children's Memorial Hospital, Chicago, and Professor of Pediatrics at the University of Chicago. He is editor of a well known system of pediatrics. As well as reading two papers Dr. Brennemann will take part in the discussion of the clinical presentations during the first two days. The Committee believe that in Dr. Brennemann they have obtained the assistance of the best man available to help in the problems of practice.

FIRST DAY

TUESDAY, FEBRUARY 14

9.00-10.00 a.m.—Registration at the Medical College.

10.00-10.15 a.m.—Welcome by Dean of the Medical College.

10.15-11.00 a.m.—Address by Dr. Joseph Brennemann, Chief of Staff, Children's Memorial Hospital, Chicago.
Random Thoughts on the Practice of Medicine.
This lecture will be given in Theatre "A" of the Medical College.

11.00-12.00 a.m.—Clinic, Rheumatic Disease in Children. Dr. J. M. McEachern, East 1, General Hospital.

12.30- 1.30 p.m.—Luncheon, General Hospital.

Some Medical Aspects of Kellogg's ALL-BRAN as an aid to elimination

1 *Medical authority concedes that "bulk" provided by food residue assists efficient elimination.*

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AFTERNOON CLINICS AT CHILDREN'S HOSPITAL

2.00- 3.00 p.m.—Treatment of the Pareses and Paralyses following Poliomyelitis. Dr. A. E. Deacon.

3.00- 4.00 p.m.—Treatment of Infantile Diarrhoea. Dr. H. E. Popham.

4.00 p.m.—Demonstration of cases in wards.

8.15 p.m.—Address by Dr. Joseph Brennemann before the Winnipeg Medical Society, to be given in the Physiology Theatre, Medical College. Subject: The Acute Abdomen in the Child.

SECOND DAY

WEDNESDAY, FEBRUARY 15

All Clinics at the Children's Hospital

9.00-10.30 a.m.—Chronic Cough in Children: A Group Symposium.

Introduction by the Chairman.

Allergy as a Cause. Dr. Gordon Chown.

Chronic Pulmonary Infection as a Cause. Dr. Harry Medovy.

Sinusitis as a Cause. Dr. F. A. Macneil.

10.30-11.00 a.m.—Demonstration of methods of testing for Allergy. Dr. C. H. A. Walton.

11.00-12.00 a.m.—On Squint. Dr. J. A. McGillivray.

12.30- 1.30 p.m.—Luncheon at the Children's Hospital.

There will be an exhibit of X-ray films which Dr. Patriarche will be glad to demonstrate before and after the luncheon.

1.30- 2.15 p.m.—Treatment of Diabetes in Children. Dr. Harry Medovy.

2.15- 3.00 p.m.—X-ray Interpretation in Diseases of the Long Bones in Children. Dr. E. Patriarche.

3.15- 4.00 p.m.—Newer Aspects of Tetany. Dr. Bruce Chown.

4.30- 6.30 p.m.—Reception at the home of Dr. and Mrs. Gordon Chown, 588 Broadway.

THIRD DAY

THURSDAY, FEBRUARY 16

All Clinics at the Children's Hospital

9.00- 9.45 a.m.—Treatment of Empyema. Dr. J. D. McEachern.

10.00-10.45 a.m.—Infantile Eczema. Dr. A. R. Birt.

11.00-11.45 a.m.—Some Classical Feeding Difficulties. Dr. O. J. Day.

12.00- 1.00 p.m.—Luncheon at Children's Hospital.

1.00- 1.45 p.m.—Anaemia in Infants and Children. Dr. J. N. Crawford.

2.00- 2.45 p.m.—Otitis Media and Mastoiditis in Children. Dr. I. H. Beckman.

3.00- 3.45 p.m.—Hypothyroidism in Children. Dr. G. Shapera.

3.45 p.m.—Demonstration of cases in wards.

SECONDARY ANEMIAS

Although copper does not enter into the formation of the haemoglobin molecule, numerous studies have revealed its importance as a "metabolic activator" for the best utilization of iron.

Abbott's Cofron Elixir is an agreeable-tasting tonic of whole liver concentrate with the copper and iron present in definite amounts. Each fluid ounce represents 1⅓ ounces of fresh liver, 1 grain of iron and 1/25 grain of copper. Cofron Elixir is indicated in non-specific conditions in which there is a decreased red cell count or a lowered haemoglobin percentage. Recovery from any weakening illness, if it has led to anaemia, will be hastened by the administration of Cofron Elixir. Detailed literature will be sent upon request. Abbott Laboratories Ltd., 388 St. Paul St. West, Montreal.

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Department of Health and Public Welfare

NEWS ITEMS

"RHEUMATIC FEVER: CHILDHOOD RHEUMATISM"

The following article on "Rheumatic Fever: Childhood Rheumatism" by Dr. May G. Wilson, Assistant Professor, Department of Pediatrics, Council University Medical College, was recently published in "Preventive Medicine" by the New York Academy of Medicine:

"Rheumatic fever owes its place as one of the most important diseases of childhood to the fact that the heart is probably always involved. Published mortality statistics for New York City reveal that rheumatic fever ranks highest as the cause of death for girls, and is second only to accidental deaths for boys. It has been estimated that 80 per cent. of adult heart disease in persons under the age of forty is of rheumatic etiology, usually acquired in childhood, and that about one per cent. of children of school age have rheumatic heart disease. Rheumatic fever is not a reportable disease, and, therefore, its actual incidence in the population is not known. The disease is more prevalent in cities of the north temperate zone where it exhibits a definite seasonal trend. In New York City the highest incidence has been observed in the early winter and spring months, with a corresponding lowered incidence in the summer months. It appears more frequently among under-privileged children, although it is observed in families of the well-to-do. There is no demonstrable racial predilection.

"It has long been recognized that the disease tends to be concentrated in certain families. Recent genetic studies of rheumatic families indicate that there may be an hereditary factor distributed among the population which makes the bearer susceptible to rheumatic fever. This factor is transmitted as a single autosomal recessive gene. The exact role of environment and contagion in the acquisition of the disease by susceptible individuals is still undetermined.

"Although the causative agent is as yet unknown, rheumatic fever is generally believed to be an infection. Its relation to other infections, particularly those of the respiratory system, is still a matter of controversy. Attempts to isolate a specific micro-organism or to transmit the disease to animals, have been unsuccessful up to the present time. Evidence has been presented recently which, if confirmed, would indicate that rheumatic fever may be due to a virus, acting alone or in association with other organisms.

"Rheumatic fever is essentially a disease of childhood, having its onset and more characteristic manifestations during this period. The usual age of onset of childhood rheumatism is in the pre-school period—at about the average age of six years. It is generally recognized that the tendency to occurrence and recurrence of the disease diminishes after puberty.

"Recent pathological studies have demonstrated the widespread distribution of vascular lesions, affecting not only the cardiac structures and peripheral vessels, but minute arteries, capillaries and veins. The selective action on connective tissues, serous membranes and vascular structures is notable in the symptomatology of childhood rheumatism.

MANIFESTATIONS OF CHILDHOOD RHEUMATISM

"Childhood rheumatism is essentially different in its symptomatology and course from the adult type of the disease. Clinical and pathological studies have revealed that the heart is usually damaged from the onset of rheumatic infection. In addition, there is concurrent and successive involvement of different tissues and structures of the body to a varying degree. Symptoms which are easily detectable often dominate the clinical picture, while symptoms and signs of cardiac involvement are more often subclinical and may escape recognition. This has led to the erroneous conception, or loose terminology, that tonsillitis, chorea or polyarthritis 'induce, result in, or are complicated by rheumatic heart disease.' These associated manifestations of rheumatic infection have been used as a measure of the severity of the infection in terms of 'resulting heart disease.' It is evident, however, that the degree of cardiac involvement in this disease is the more accurate index of the severity of the infection, and not the presence or absence of any of the other associated manifestations.

"The onset of rheumatic fever is usually characterized by general symptoms of infection: fever, leukocytosis, increased sedimentation rate, anemia, loss of weight and fatigability; symptoms which are not peculiar to rheumatic fever but which may be present in any of the acute and chronic infections of childhood, such as sinusitis, childhood type of tuberculosis, undulant fever and blood dyscrasias. A diagnosis of rheumatic disease can usually be made in the presence of signs of involvement of: the cardiac structures—subacute and acute carditis; the peripheral vessels, arterioles and capillaries—cutaneous manifestations, abdominal pain and chorea; the connective tissues—growing pains, joint pains, polyarthritis and subcutaneous nodules. These signs and symptoms, with the exception of carditis, and, possibly, of rheumatic nodules, are not in themselves pathognomonic of rheumatic fever and may be present in other infections. The onset of rheumatic fever may be ushered in by any or all of the protean manifestations of the disease. In children the usual course of the disease is characterized by recurrences of any of the manifestations, in successive years or after varying numbers of years of freedom from symptoms. Acute and subacute carditis is unrecognized in the majority of children who are later found to have rheumatic heart disease. The extent of cardiac damage in these children is usually far less than in those who have exhibited recognizable signs and symptoms of active carditis. During the intervals when children with rheumatic heart disease are free from symptoms of rheumatic infection, they are able to carry on their normal activity without any circulatory symptoms. The physical signs of cardio-valvular disease regress in a large percentage of these children.

PREVENTION AND CONTROL OF CHILDHOOD RHEUMATISM

"It is evident from this brief summary of our knowledge of the natural history of rheumatic fever that specific measures are not as yet available for the prevention and control of this disease. There is, however, some evidence which would indicate that certain general measures may be of value.

"The concept that an hereditary susceptibility underlies the familial tendency of rheumatic fever, would indicate that eugenic principles may have a practical application in this disease.

"The strikingly lower incidence of rheumatic fever in children of the well-to-do, living in New York City within a few blocks of the tenement districts from which our clinic children are drawn, would indicate that unfavorable environmental conditions may play a contributing role in its prevalence among the poor. Provision of decent housing would eliminate over-crowding

and furnish adequate plumbing, heating and ventilation. Improvement in economic status would provide sufficient warm clothing to reduce the chance of chilling, and adequate food for the maintenance of proper nutrition. The eventual establishment of these preventive measures is a goal to strive for in the broad field of public health.

"The increased incidence of the disease in the early winter and spring months and its lowered incidence in the summer months in New York City indicate that the avoidance of exposure to inclement weather by susceptible children during the seasons when the disease is prevalent, is essential. Such a program would require the active co-operation of the school authorities to arrange for intermittent school attendance. The reported low incidence of rheumatic fever in tropical and sub-tropical localities would indicate that continued residence of susceptible children in sections of the country where the climate is equable, might prove beneficial. However, there is as yet no conclusive evidence to support this notion.

"These suggested preventive measures should be directed particularly toward the children of families of known rheumatic background. The regime which has been found valuable in the management of the pre-tuberculous child may equally well be applied to the hereditarily 'susceptible' rheumatic child. The prevention of intercurrent infections and over fatigue are of great importance.

"These measures for the prevention of the disease should be equally valuable in the prevention of recurrences of rheumatic relapses. There is no conclusive evidence to support the use of any 'specific' therapeutic measure, such as tonsillectomy sera, vaccines or drugs, in childhood rheumatism. At the onset of symptoms of rheumatic infection and throughout the entire course, adequate bed rest and intelligent nursing care are essential. The treatment is mainly symptomatic. The medication usually comprises anti-pyretic drugs and sedation. The symptoms of congestive failure may necessitate the use of digitalis and diuretics. A sufficiently prolonged period of convalescent care is of the utmost importance. This is best given in institutions properly equipped for the care of such patients. The variability in duration of the manifectations of activity in any one child indicates that the disease is self limited. Termination of the convalescent period with return to normal activity is permissible only following subsidence of signs and symptoms of active infection. This is frequently indicated by progressive gain in weight and a normal reaction to ordinary activity.

"Until the cause of the disease is known and more accurate information as to its incidence is available, our efforts to prevent and control rheumatic fever should be directed toward the objective of improving the environmental conditions of children of rheumatic families. Proper hygiene, adequate food, sufficient clothing, avoidance of over fatigue and intercurrent infections, should be reflected in a diminished incidence of rheumatic fever among children of that social class in which the disease appears to be most prevalent."

COMMUNICABLE DISEASES REPORTED

Urban and Rural — December, 1938.

Occurring in the Municipalities of:

Whooping Cough: Total 178—Woodworth 100, Winnipeg 12, Rivers 9, Kildonan East 6, Brandon 2, Daly 2, St. Boniface 2, Argyle 1, St. James 1, Unorganized 1 (Late Reported: September, Unorganized 2; October, Unorganized 18; November, Unorganized 21, Ste. Rose 1).

Scarlet Fever: Total 124—Winnipeg 58, Unorganized 7, Brandon 6, Miniota 5, Portage Rural 5, Rivers 5, St. Andrews 5, Woodworth 5, Cameron 4, Pembina 4, Transcona 3, Blanshard 2, Kildonan East 2, Portage City 2, Brooklands 1, Daly 1, Lac du Bonnet 1, Louise 1, Morton 1, Rockwood 1, Roland 1, Shell River 1, Siglunes 1, St. Boniface 1, St. Vital 1.

Measles: Total 117—Lorne 35, Argyle 16, Victoria 15, Franklin 10, Winnipeg 3, Oakland 8, Brandon 4, Roblin Rural 4, Turtle Mountain 2, Brokenhead 1, Cypress South 1, Daly 1, Kildonan West 1, Morden 1, Norfolk North 1, Riverside 1, Strathcona 1 (Late Reported: November, Lorne 12).

Chickenpox: Total 113—Winnipeg 16, Dauphin Town 16, Kildonan West 16, Unorganized Territory 15, Transcona 9, Blanshard 7, Flin Flon 4, Morris Rural 3, St. Boniface 3, St. Francois 2, Arthur 1, Brandon 1, Melita 1, Portage City 1, Roblin Rural 1, Rockwood 1, Shell River 1, St. Andrews 1, St. Clements 1, St. James 1 (Late Reported: August, Kildonan West 2; November, St. Clements 8, Kildonan West 1, Unorganized 1).

Mumps: Total 100—Winnipeg 67, St. James 21, Kildonan East 9, Unorganized 2, Riverside 1.

Diphtheria: Total 30—Winnipeg 13, Flin Flon 10, Unorganized Territory 3, Hanover 2, Norfolk North 1, St. Andrews 1.

German Measles: Total 12—(Late Reported: November, Unorganized 12).

Erysipelas: Total 9—Winnipeg 5, Brooklands 1, La Broquerie 1, St. James 1, St. Vital 1.

Smallpox: Total 8—Swan River Rural 6, St. Francois 2.

Tuberculosis: Total 8—Winnipeg 7, Boulton 1.

Septic Sore Throat: Total 6—Woodlea 5, Rossburn Rural 1.

Anterior Poliomyelitis: Total 5—St. Laurent 1 (Late Reported: November, Brokenhead 2, St. Vital 2).

Influenza: Total 5—(Late Reported: November, Blanshard 1, Grandview Rural 1, Portage Rural 1, Ritchot 1, Ste. Anne 1).

Diphtheria Carrier: Total 5—Unorganized 2, Cartier 1, Flin Flon 1 (Late Reported: November, Unorganized 1).

Typhoid Fever: Total 3—Hanover 2, Dufferin 1.

Cerebrospinal Meningitis: Total 2—Dufferin 1 (Late Reported: November, Grey 1).

Typhoid Paratyphoid A.: Total 2—Franklin 1, Unorganized 1.

Venereal Disease: Total 131—Gonorrhoea 57, Syphilis 74.

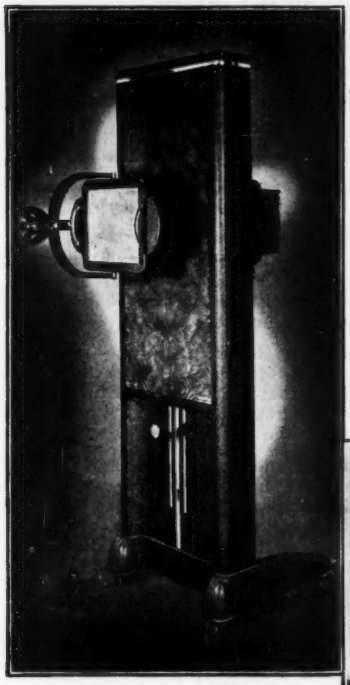
DEATHS FROM ALL CAUSES IN MANITOBA

For the Month of November, 1938

URBAN—Cancer 34, Pneumonia 12, Syphilis 4, Tuberculosis 4, Diphtheria 3, Influenza 2, Cerebrospinal Meningitis 1, Typhoid Fever 1, Septic Throat 1, Whooping Cough 1, all others under one year 14, all other causes 165, Stillbirths 12. Total 254.

RURAL—Cancer 37, Pneumonia 22, Tuberculosis 20, Influenza 6, Whooping Cough 4, Diphtheria 2, Scarlet Fever 1, Typhoid Fever 1, all others under one year 28, all other causes 155, Stillbirths 18. Total 294.

INDIANS—Tuberculosis 7, Pneumonia 5, all others under one year 5, all other causes 2, Stillbirths 1. Total 20.



● **Above**—Self-contained fluoroscope with controls mounted in screen carriage arm. Patterson type "B" screen. Panel is pure grain-free bakelite. Apparatus may be had with remote control stand.

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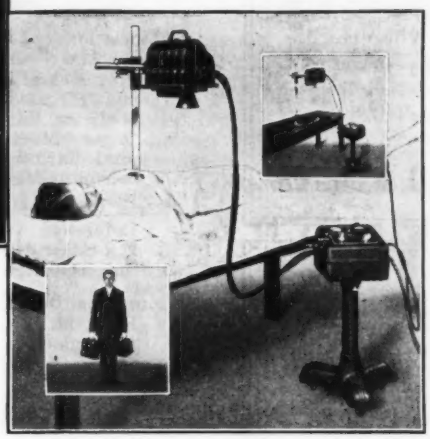

● **Left**—View of portable radiographic unit. Insets show construction and portability. This portable unit also provides fluoroscopy with hand fluoroscope. May be purchased separately with or without remote control.

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Current Medical Literature

"The British Medical Journal"—December 24, 1938

"Modern Views in the Prevention of Tuberculosis"—by D. M. Dunlop, M.D., F.R.C.P. (Ed.), Physician, Royal Infirmary, Edinburgh.

"Four Cases of Weil's Disease Infected from the Same Stream"—by Kenneth M. Robertson, M.D., M.R.C.P., Honorary Physician, Royal Hampshire County Hospital, Winchester.

"Mastoid Operations—A Further Study"—by Walter Howarth, M.A., M.B., F.R.C.S., Surgeon to the Ear, Nose and Throat Department, St. Thomas's Hospital, and Geoffrey Bateman, B.M., F.R.C.S., Chief Assistant to the Department.

"Association of Stammering and The Allergic Diatheses"—by A. M. Kennedy, M.D., F.R.C.P., Professor of Medicine in the University of Wales and Director of the Medical Unit, School of Medicine, Cardiff, and D. A. Williams, B.Sc., M.D., Deputy Medical Superintendent, Llandough Hospital, Cardiff; Late Assistant in the Medical Unit, School of Medicine, Cardiff.

"Three Cases of Intussusception in the Adult—With Reference to Aetiology"—by C. L. Heanley, F.R.C.S., M.R.C.P., Surgical First Assistant and Surgical Registrar, London Hospital.

"Congenital Deformities of Legs"—by Reginald Broomhead, M.B., Ch.B., F.R.C.S., Honorary Surgeon, Orthopaedic Department, General Infirmary, Leeds; Lecturer in Orthopaedics, University of Leeds.

"Edinburgh Medical Journal"—November, 1938.

"Traumatic Meningeal Haemorrhage, with a Review of Seventy-one Cases"—By J. Hogarth Pringle, F.R.C.S. (Eng.), Glasgow.

"Harvey in Scotland"—by Henry Wade, C.M.G., D.S.O., F.R.C.S. (Ed.).

"Results of Recent Studies on Anterior Pituitary Hormones"—by J. B. Collip, from the Department of Biochemistry, McGill University, Montreal, Can.

Clinical Recollections and Reflections — XXVII. "Lister and His Contemporaries in Edinburgh"—by C. E. Douglas, M.D., LL.D., F.R.C.S. (Ed.).

"Isolation of the Bacillus Tuberculosis from Sputum; Comparison of the Antiformin and Sulphuric Acid Methods"—by A. Saenz and J. T. Paterson, from the Institut Pasteur, Paris.

"The Practitioner"—January, 1939.

"The Importance of Diet and General Treatment in Dermatology"—by H. W. Barber, M.B., B.Ch., F.R.C.P., Physician in Charge of the Skin Department, Guy's Hospital, London.

"Psychological Factors in Skin Diseases"—by C. H. Rogerson, M.D., M.R.C.P., D.P.M., Medical Director, Cassel Hospital for Functional Nervous Disorders, Penshurst.

"Significance and Treatment of Itching"—by W. N. Goldsmith, M.A., M.D., F.R.C.P., Assistant Physician to the Skin Department, University College Hospital; Physician, St. John's Hospital for Diseases of the Skin; Physician for Diseases of the Skin, the West End Hospital for Nervous Diseases.

"Pyogenic Infections of the Skin"—by G. H. Percival, M.D., Ph.D., F.R.C.P. (Ed.), D.P.H., Physician to the Skin Department, Royal Infirmary, Edinburgh; Lecturer in Diseases of the Skin, University of Edinburgh; Dermatologist to the Edinburgh Corporation.

"The Diagnosis and Treatment of Common New Growths of the Skin"—by Sydney Thomson, M.A., M.D., F.R.C.P., F.R.S. (Ed.), Physician in Charge of the Skin Department, King's College Hospital, London.

"The Modern Treatment of Eczema"—by F. F. Hellier, M.A., M.D., M.R.C.P., Honorary Assistant Physician to the Skin Department, The General Infirmary, Leeds.

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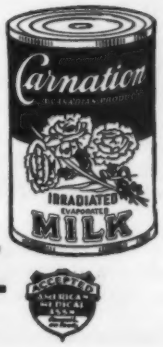

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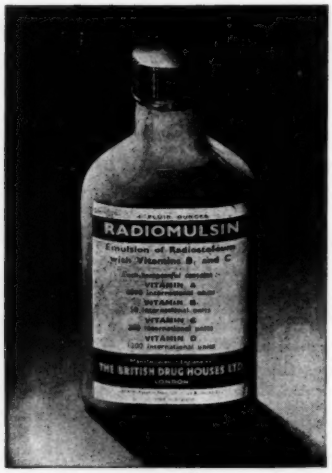

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Clinical Section

Allergic Diseases of Infancy and Childhood*

By

ALBERT V. STOESSER, M.D., Ph.D.

Associate Professor of Pediatrics

University of Minnesota, Minneapolis

Allergy, which means altered reactivity, is a term introduced by Von Pirquet and Schick[1] at the time they were studying serum sickness, a condition which exists in many individuals after receiving therapeutic serums. Doerr[2] later used the term to apply to all phenomena of hypersusceptibility in animals and in man, and Zinsser[3] also was in favor of using the word allergy to designate this interesting field of medicine. We find, however, under the general heading, allergy, the existence of a great deal of confusion when any attempt is made to classify and correlate the various experiments with animals by numerous workers and the clinical observations of many physicians.

The terms anaphylaxis, allergy and hypersensitiveness are used interchangeably in the medical literature. An effort has therefore been made at this time after a careful survey of the reports of some of the leading observers in this field to present a classification or outline with the hope that it will be of some value in the diagnosis and possibly in the prognosis and the treatment of allergic conditions.

I. Anaphylaxis or anaphylactic hypersensitiveness (artificially produced allergy).
   - A. In animals—experimental.
   - B. In man—anaphylactic shock in a previously sensitized individual.
   - C. Drug anaphylaxis in man.

II. Natural or human hypersensitiveness (allergy by natural acquisition).
   - A. Serum allergy or sickness (delayed anaphylactic reaction).
   - B. Drug allergy or idiosyncrasy.
   - C. Contact dermatitis.
   - D. Contact allergic coryza (vasomotor rhinitis).
   - E. Atopy or atopic hypersensitiveness (allergy through heredity).
     1. Atopic or allergic dermatitis.
        - (a) Acute eczema (so-called "true eczema" of infancy).
        - (b) Chronic eczema (so-called "neurodermatitis" of childhood).
     2. Allergic coryza (atopic, hyperesthetic or vasomotor rhinitis) due to:
        - (a) Inhalants
          - (1) Animal emanations.
          - (2) Pollens (hay fever or pollinosis).
          - (3) Powders and perfumes.
        - (b) Foods and drugs.
        - (c) Bacterial products of infection.
     3. Bronchial asthma due to
        - (a) Inhalants.
        - (b) Foods and drugs.
        - (c) Bacterial products.
     4. Other allergic conditions:
        - (a) Urticaria (and angioneurotic edema).
        - (b) Gastro-intestinal allergy (food allergy).
        - (c) Allergic migraine.
        - (d) Puroura (Henoch's).
        - (e) Vernal conjunctivitis.
        - (f) Some cases of epilepsy.
     5. Serum and drug shock in the atopic individual.

III. Hypersensitiveness in infection (allergy acquired through infection).
   - A. Bacterial allergy or hyperergia.
     1. Tuberculosis.
     2. Allergy has been considered in:
        - (a) Rheumatic fever.
        - (b) Scarlet fever.
        - (c) Nephritis.
        - (d) Lobar pneumonia.
   - B. Fungous and parasitic infections may produce allergic reactions.

The name atopy, which means "a strange disease" was coined by Coca,[4] a leading American investigator in the field of allergy. He included all those clinical forms of hypersensitiveness which occur so far as is known only in human beings and which are subject almost entirely to inheritance.

The substance to which the atopic individual responds in an abnormal way are called "atopens", and they may be proteins or non-proteins. These individuals react with specific bodies which may be found in the blood of nearly all cases. Whether these bodies which have been called atopic reagins are true antibodies developed immunologically under antigen stimulation or physiological products like the natural hemoagglutinins and hymolysins is not known.

The purpose of this communication is to summarize the experience which we have had during the past six years in taking care of allergic children. There were 373 cases which were distributed as follows: eczema, 115 (30.8 per cent.); allergic coryza, 46 (12.4 per cent.); hay fever, 51 (13.6 per cent.); bronchial asthma, 141 (37.8 per cent.); urticaria, 17 (4.6 per cent.); and gastro-intestinal allergy, 3 (0.8 per cent.). All of these allergic disorders may be grouped under that subheading of natural or human hypersensitiveness entitled atopy or atopic hypersensitiveness.

* From the Allergy Clinic and Service of the Department of Pediatrics, University Hospital, Minneapolis, Presented before the Winnipeg Medical Society at Winnipeg on March 18th, 1938.

The atopic children were handled in the allergy clinic in a rather simple manner. Nothing elaborate was attempted. An effort was made to follow some definite program in searching for the cause of the allergic disorder. First of all, a very complete history was obtained. It was observed that in many instances a good history was really the key to success in the treatment. Special emphasis was placed on the time of onset, the outstanding symptoms, the course of the disease from month to month, or year to year, the previous allergic disorders, the associated or concomitant allergic disorders, and the family history. A search was made for allergic disorders among immediate members of the family and blood relations. Several history outlines were tried in obtaining good records but none was found to be quite as satisfactory as the one that follows:[5, 6]

I. PRESENT ILLNESS. Sex Age Date
- A. Duration. Date of onset.
- B. First attack: Gradual or sudden onset and early symptoms.
- C. Suspected cause of onset (illness or operation)?
- D. What brought relief?
- E. Frequency of attacks.
- F. Duration of attacks.
- G. When worse (time of year)?
- H. Seasonal only?
  Dates.
- I. Chief symptoms at present time:
- J. Free from symptoms at any time?
  Dates.
- K. Where living at that time?
- L. Any symptoms between attacks?
- M. Treatment received up to the present time:
- N. Success of treatment.

II. PAST HISTORY.
- A. Infancy.
  1. Infantile eczema?
     Dates.
  2. Breast-fed how long?
     Bottle-fed how long?
  3. Food disagreements.
     Any foods cause any symptoms?
- B. Childhood (circle positive findings).
  1. Any chronic or recurrent rhinitis, bronchitis, croup, cyclic vomiting or frequent gastro-intestinal disturbances?
  2. Any eczema, allergic coryza, hay fever, asthma, urticaria, gastro-intestinal allergy, purpura?
     Dates.
  3. Were these continuous?
     Seasonal? When worse?
  4. Any suspected cause?
  5. Treatment received?
  6. Success of treatment.
- C. History by symptoms (record other symptoms besides those listed).
  1. Head — headache (unilateral or bilateral).
  2. Scalp—itching and seborrhea.
  3. Eyes—itching and burning.
  4. Nose—blockage, discharge, sneezing.
  5. Ears—itching.
  6. Mouth and throat—irritation, dryness.
  7. Chest—dyspnea, chronic cough, chronic expectoration (amount and type).
  8. Heart—tachycardia.
  9. Gastro-intestinal — constipation, diarrhea, abdominal distress, nausea, vomiting.
  10. Genito-urinary—bladder distress.
  11. Bones and joints—pain.
  12. Nervous system—irritability, depression.
  13. Skin.
      (a) Location of lesions.
      (b) Characteristic lesion (erythema, papules, vesicles, crusts, swelling thickening, plagues).
      (c) Pruritis or itching.
      When worse? Related to meals? Cyclic? Related to dust?
  14. Weight—loss or gain?
      How long a period?
  15. Operations (especially of the nose and throat).
      Type of operation? Results?
- D. Diet and environment.
  1. Foods (cereals, egg, milk, fish, meats, vegetables, fruit, nuts, spices and condiments, chocolate and cocoa, honey, beverages).
     (a) Any dislikes or disagreements?
     (b) Worse after meals?
     (c) Any which cause asthma, increased itching, urticaria, weeping, etc.?
  2. Animals—Note effects of contact with any of the following:

Cat	Chicken	Cow
Dog	Parrot	Sheep
Canary	Horse	Other Animals

  3. Bedding—Note the type and age of the following:

Pillows	Blankets
Mattresses	Comforters

  4. Furnishings—Note the type and age of the following:
     Furniture (wood or metal)
     Upholstery (leather or cloth)
     Stuffing in furniture
     Drapes and Rugs (mothproofed?)
  5. Clothing—Note the type and age of the articles used:

Wool	Silk	Furs
Cotton	Rayon	

  6. Physical agents:

Heat	Sun	Water
Cold	Wind	

  7. Miscellaneous:
     (a) Dusts (especially house dust), fumes, etc.
     (b) Cosmetics—Note type and effect of use.
     (c) Insecticides—Note type used and frequency of use.
     (d) Drug idiosyncrasy—Note effect of drugs used locally or by mouth.
  8. Residence (city or country?)
     Any recent change?
  9. Home (house old or new?)
     Damp or musty?

III. FAMILY HISTORY.

A. Note the presence of: Eczema, allergic coryza or rhinitis, hay fever, asthma, urticaria, gastro-intestinal or food allergy, migraine in:

1. Mother, Father, Sisters, Brothers.
2. Grandparents, Aunts, Uncles.

B. Does the color of the eyes correspond to that of the mother or father?

Each child received a complete physical examination with special emphasis being placed on a careful observation of the nose and throat. A note was made as to whether the tonsils and adenoids had already been removed. A record was also kept of the number of sinus or antrum punctures the patient had received. Roentgenograms of the paranasal sinuses and the lungs were obtained in all cases with allergic disorders of the respiratory tract. Blood studies were made, and the differential counts were closely followed. As a whole very few outstanding physical defects were found among the allergic children.

Cutaneous tests were next applied. The glycerinized fluid extracts of the various atopens or allergens were used. The material is furnished in capillary tubes, there being enough of the fluid extract in each tube for one test. In this way there is no danger of contamination or spilling which occasionally occurs with the dry extracts. There is also no need for the hypodermic needles, syringes and cleansing solutions which are so essential in performing the intradermal tests.

The tests were applied by the pressure-puncture method. This was found to be the best method for infants and small children, especially when they would not remain quiet. The skin was cleansed with alcohol or ether, and after evaporation, the extract was expelled from the glass capillary tubes upon the cleansed skin at intervals of about four centimeters. Holding a sterile sewing needle nearly parallel with the skin, four oblique pricks or shallow punctures were made through the epidermis by pressing the point of the needle through each drop of extract. A new needle was used for each test. The punctures were confined to an area not more than three millimeters in diameter.

Sufficient fluid extract to produce a positive reaction in susceptible children was carried into the skin by these multiple punctures, and so in a few minutes the excess fluid on the surface of the skin was lightly wiped off. A similar test was carried out with a control glycerine solution and only those reactions in the test sites which were distinctly greater in intensity than that resulting from the control test were considered positive. The positive reactions (urticarial wheal surrounded by a zone of erythema) usually appeared in sensitive patients in 20 to 30 minutes.[7, 8, 9]

The intracutaneous tests were used in the older children. The following method was employed. The outer aspect of the arm or the anterior aspect of the thigh was used. The skin was cleansed with alcohol and dried. A graduated 1 cc. (tuberculin) syringe with a hypodermic needle of 27 gauge and a half inch in length was selected. After loading the syringe and ejecting all air bubbles, the needle was inserted into the corium through the integument. Not more than 0.01 cc. of the sterile extract was injected. Control tests were similarly made with sterile extracting fluid. The tests were observed and read within ten to fifteen minutes.

The cutaneous tests were found to be of great value in hay fever and asthma, and of least value in urticaria and gastro-intestinal allergy. The size of the skin reaction was not always an indication of the importance of the test. A small response (erythema) could indicate sensitivity of clinical value. On the other hand, many markedly positive tests were of little value.

With the increasing use of the skin for the detection of various sensitivities it is important to keep in mind that the reactions elicited in the skin give merely a visible record in part at least of the immunologic past history of the patient and per se do not portray a present illness. A correlation between positive tests and the history and observations in the allergic patient is necessary for an accurate diagnosis. The question of variations in technique as well as irritability of reagents in nervous, emotional and physiologic activity, as well as the choice of the skin area tested, greatly affect the reactivity to the tests. The differences in interpretations frequently leave the management of the patient in a most unsettled state. Whether the skin test is pressure-puncture or intracutaneous, the accuracy of the conclusions must rest in the close correlation of symptoms and course with exposure and withdrawal respectively of the substances incriminated by this method of detection.[10]

When the results of the cutaneous tests were negative or unsatisfactory, the so-called elimination of trial diets were tried. In the older infant and in the young child, these diets were often very valuable. Numerous diets eliminating various foods were used. It was found that in the majority of the cases one or more of the following foods were responsible for the allergic manifestations: milk, cheese, egg, whole wheat, white potato, chocolate, tomato and orange. If the removal of these foods did not give satisfactory results, then diets eliminating beef, chicken, oatmeal, rye, peas, beans, spinach, apple or grape were tried.

Experience shows that success in connection with the trial diets depends in many instances upon the thoroughness with which they are carried out by the parents. A great deal of time must therefore be taken in explaining each diet in detail, emphasizing especially all positive sources of error. The general health of the children on elimination diets should be closely watched. Be sure the infant or child receives the proper number of calories, a sufficient amount of the minerals such as calcium and phosphorus, and an adequate supply of vitamins. In some instances, milk can gradually be returned to the diet in

the form of evaporated milk or a powdered milk.[11, 12, 13, 14]

The diagnostic procedures mentioned above were applied to all the children studied in our allergy clinic. For economy of space and for the sake of clearness, the data obtained from all the histories, physical examinations, cutaneous tests, and elimination diets together with the treatment which was instituted has been condensed into six tables which are practically self-explanatory. An analysis of the information obtained in determining the cause of the allergic disease in each individual case together with the experiences encountered in the treatment leads up to the following facts, many of which are most helpful to the practicing physician called upon to take care of an allergic child.

TABLE 1. ECZEMA OF INFANCY AND CHILDHOOD — 115 cases (30.8 per cent.)

1. Sex: Male	60
Female	55
2. Age at First Visit:	
Below 1 year	44
1 to 5 yrs. incl.	37
6 to 10 yrs. incl.	18
11 to 15 yrs. incl.	16
3. Age at Onset:	
Below 1 year	84
1 to 5 yrs. incl.	23
6 to 10 yrs. incl.	4
11 to 15 yrs. incl.	4
4. Previous Allergic Disorders	0
5. Associated Allergic Disorders:	
Bronchial asthma	7
Hay fever	2
Urticaria	1
6. Family History:	
Positive	63
Negative or unknown	52
7. Physical Examination:	
Overweight (10%)	6
Otitis media	10
Mental retardation	2
Impetigo	1
Pneumonia	1
8. Eosinophile Differential Count:	
Below 5 per cent.	65
5 to 10 per cent.	25
Over 10 per cent.	13
No count	12
9. Cutaneous Tests:	
Positive	64
Negative or refused	51
10. Treatment	
Positive skin tests	
Removal from diet of	
Egg	12
Egg and wheat	5
Egg, wheat and milk	1
Egg, wheat and chocolate	1
Egg and milk	2
Egg and peas	1
Wheat	3
Wheat and oatmeal	1
Wheat, oatmeal and milk	2
Milk	7
Codfish	1
Tomato and orange	1
Orange and chocolate	1
Chicken and cheese	1
Contact with ragweed	2
Removal of silk	1
Removal of rayon	1
Referred into hospital	12
Treatment unsuccessful	9
Negative or no skin tests	
Elimination diets used with removal from diet of	
Egg	6
Egg and wheat	6
Egg, wheat and milk	3
Egg and potato	1
Wheat	2
Milk	3
Milk and potato	1
Potato	1
Chocolate	1
Tar alone very effective	15
Referred into hospital	5
Treatment unsuccessful	7

Note: In this table and the succeeding ones the numerals in each column indicate the number of cases.

TABLE II. ALLERGIC CORYZA (ATOPIC RHINITIS) — 46 cases (12.4 per cent.)

1. Sex: Male	33
Female	13
2. Age at First Visit:	
Below 1 year	0
1 to 5 yrs. incl.	8
6 to 10 yrs. incl.	20
11 to 15 yrs. incl.	18
3. Age at Onset:	
Below 1 year	0
1 to 5 yrs. incl.	31
6 to 10 yrs. incl.	15
4. Previous Allergic Disorders:	
Infantile eczema	8
5. Associated Allergic Disorders:	
Bronchial asthma	5
Chronic eczema	4
Urticaria	3
Hay fever	1
6. Family History:	
Positive	40
Negative or unknown	6
7. Physical Examination:	
Large tonsils	7
Ear infection	2
Adolescent goiter	1
8. Tonsils (at first visit)	
Present	18
Removed	28
9. Maxillary Sinus Roentgenograms:	
Positive	25
Negative	21
10. Eosiniphile Differential Count:	
Below 5 per cent.	23
5 to 10 per cent.	11
Over 10 per cent.	8
No count	4
11. Cutaneous Tests (pressure-puncture or intradermal or both):	
Positive	16
Negative	30
12. Treatment	
Skin tests of value	
Symptom free after removal of	
Mustard	1
Banana, grape and pineapple	1
Egg and feathers	1

Feathers	5
Cat (dander)	2
Cat and orris root	1
Orris root	1
Goat	1
Skin tests of no value	
Improvement followed after removal of	
Egg	4
Egg and wheat	3
Egg, wheat and milk	1
Wheat	2
Wheat and potato (sinus drainage)	1
Milk	1
Tomato and apple	1
Apple and feathers	1
Feathers and reduction of house dust	1
Feathers and house dust	1
House dust	1
Removal of tonsils and adenoids	3
No improvement	11

TABLE III. HAY FEVER (POLLINOSIS)

51 cases (13.6 per cent.)

1. Sex: Male	44
Female	7
2. Age at First Visit:	
Below 1 year	0
1 to 5 yrs. incl.	4
6 to 10 yrs. incl.	24
11 to 15 yrs. incl.	23
3. Age at Onset:	
Below 1 year	1
1 to 5 yrs. incl.	23
6 to 10 yrs. incl.	21
11 to 15 yrs. incl.	6
4. Previous Allergic Disorders:	
Infantile eczema	10
Bronchial asthma	5
Urticaria	2
5. Associated Allergic Disorders:	
Bronchial asthma	10
Gastro-intestinal allergy	3
Chronic eczema	1
Urticaria	1
Allergic coryza	1
6. Family History:	
Positive	39
Negative or unknown	12
7. Physical Examination:	
Large tonsils	5
Ichthyosis	1
8. Tonsils (at first visit):	
Present	25
Removed	26
9. Maxilliary Sinus Roentgenograms:	
Positive	28
Negative	18
No record	5
10. Eosinophile Differential Count:	
Below 5 per cent.	24
5 to 10 per cent.	19
Over 10 per cent.	4
No count	4
11. Cutaneous Tests:	
Positive	47
Negative	2
Refused	2
12. Treatment:	
Hyposensitization—good results	
Grasses	1
Russian thistle group	2
Wormwood—sage group	4
Ragweed group	24
Grasses and ragweed	7
Hyposensitization in progress the first time	2
Moved from Minnesota	2
Hyposensitization refused	6
No treatment	3

TABLE IV. BRONCHIAL ASTHMA

141 cases (37.8 per cent.)

1. Sex: Male	105
Female	36
2. Age at First Visit:	
Below 1 year	3
1 to 5 yrs. incl.	30
6 to 10 yrs. incl.	62
11 to 15 yrs. incl.	46
3. Age at Onset:	
Below 1 year	24
1 to 5 yrs. incl.	79
6 to 10 yrs. incl.	29
11 to 15 yrs. incl.	9
4. Previous Allergic Disorders:	
Infantile eczema	56
Hay fever	6
Urticaria	5
5. Associated Allergic Disorders:	
Hay fever	18
Chronic eczema	12
Urticaria	12
Allergic coryza	1
6. Family History:	
Positive	108
Negative or unknown	33
7. Physical Examination:	
Large tonsils	28
Barrel chest	12
Malnutrition	7
Nasal polyps	2
Adolescent goiter	1
8. Tonsils (at first visit):	
Present	84
Removed	57
9. Maxillary Sinus Roentgenograms:	
Positive	86
Negative	55
10. Eosinophile Differential Count:	
Below 5 per cent.	48
5 to 10 per cent.	51
Over 10 per cent.	29
No count	3
11. Cutaneous Tests:	
Positive	108
Negative or refused	33
12. Treatment:	
Positive tests of value	
Removal of foods	
Egg	2
Egg and wheat	1
Egg, cereals, milk and meat	1
Wheat	2
Milk	2
Rye	1
Grape	1
Peanut	1
Removal of inhalants	
Horse dander	9
Horse and cow dander	4
Horse and feathers	1
House dust	7
Cat dander	3
Feathers	15
Feathers and dog	2
Orris root	1
Fish glue	1

Removal of foods and inhalants	
Egg and feathers	2
Cereals, peas and feathers	1
Hyposensitization	
Grass groups	2
Ragweed group	11
Tree and ragweed	3
Grass and ragweed	10
Removal of foods and hyposensitization	5
Feathers and hyposensitization	2
House dust and hyposensitization	2
Positive tests of no value	
Potassium iodide and belladonnae gave most relief	7
Removal of tonsils and adenoids with sinus drainage	3
Moved from Minnesota	1
Tests negative or refused	
Removal of	
Egg	2
Egg, wheat and feathers	1
Wheat and feathers	1
Feathers	3
House dust	2
Horse and cow dander	1
Removal of tonsils and adenoids	2
Infection	3
Treatment unsuccessful	24

TABLE V. URTICARIA — 17 cases (4.6 per cent.)

1. Sex: Male	6
Female	11
2. Age at First Visit:	
Below 1 year	2
1 to 5 yrs. incl.	6
6 to 10 yrs. incl.	3
11 to 15 yrs. incl.	6
3. Age at Onset:	
Below 1 year	4
1 to 5 yrs. incl.	7
6 to 10 yrs. incl.	3
11 to 15 yrs. incl.	3
4. Previous Allergic Disorders:	
Infantile eczema	1
5. Associated Allergic Disorders:	
Gastro-intestinal	3
6. Family History:	
Positive	5
Negative	10
7. Physical Examination:	
Large tonsils	1
Many dental caries	1
8. Tonsils (at first visit)	
Present	15
Removed	2
9. Maxillary Sinus Roentgenograms:	
Positive	1
Negative	16
10. Eosinophile Differential Count:	
Below 5 per cent.	14
5 to 10 per cent.	3
11. Cutaneous Tests:	
Positive	4
Negative	9
Unsatisfactory	4
12. Treatment	
Skin tests of value	
Symptoms free after removal of Tomato, carrot, orange, apple and chocolate	1
Banana, grape and pineapple	1
Skin tests of no value, negative or unsatisfactory	
Elimination diets used with relief after removal of	
Egg and wheat	1
Egg, wheat, potato, tomato, orange and chocolate	2
Egg, milk and spinach	1
Milk	1
Tomato	2
Tomato and orange	1
Removal of wool	1
Avoidance of heat (hot baths)	2
Alkaline ash diet and alkali	1
Treatment unsuccessful	3

TABLE VI. GASTRO-INTESTINAL ALLERGY
3 cases (0.8 per cent.)

1. Sex: Male	0
Female	3
2. Age at First Visit:	
Below 1 year	0
1 to 5 yrs. incl.	1
6 to 10 yrs. incl.	0
11 to 15 yrs. incl.	2
3. Age at Onset:	
Below 1 year	0
1 to 5 yrs. incl.	1
6 to 10 yrs. incl.	2
4. Previous Allergic Disorders:	0
5. Associated Allergic Disorders:	0
6. Family History:	
Positive	1
Negative	2
7. Physical Examination:	
Large tonsils	1
8. Tonsils (at first visit):	
Present	3
Removed	0
9. Maxillary Sinus Roentgenograms:	
Positive	0
Negative	3
10. Eosinophile Differential Count:	
Below 5 per cent.	2
5 to 10 per cent.	1
11. Cutaneous Tests:	
Positive	1
Negative	2
12. Treatment	
Skin tests of value	
Symptoms free after the removal of cheese	1
Skin tests of no value and elimination diets used	
Improvement followed after the removal from diet of	
Milk and wheat	1
Wheat and chocolate	1
Before treatment subjects had vomiting and abdominal pain or colic. One case complained of headaches.	

Table I. represents the data secured from the children with eczema. There is more or less an equal distribution as to sex. The onset of this allergic condition is very early in life so that it is usually not preceded by any other allergic disease. Very few cases have associated allergic disorders. With the onset of another allergic condition, the eczema may suddenly disappear. Many cases of eczema reveal positive inhalant or pollen tests and these cases later develop allergic coryza, hay fever, or asthma. Food atopens (allergens) play an important part as causative

agents in atopic or allergic eczema of infancy and childhood. Cutaneous tests, however, do not assist in some cases in determining this food allergy. Elimination or trial diets must be used. The eczematous infants on artificial feeding and with only marked egg white sensitivity by cutaneous testing constitute the most difficult group to treat. The external application of tar still remains a fairly good form of treatment. The single use of the elimination diet, of tar, or of any other treatment does not always give entirely satisfactory results. Various combinations of therapy are now considered to be most effective. Some infants have skin disorders which resemble very closely atopic eczema but which are probably not due to an allergic disturbance. Many of these cases have a negative family history for allergic disorders. Contact dermatitis is rare.

The allergic disorders with predominant nasal manifestations are considered in Tables II. and III. There is allergic coryza with its characteristic perennial history, and hay fever or pollinosis with its strong seasonal occurrence. The incidence of these disorders appears to be greater in the males than in the females. Many cases of allergic coryza have their onset during the preschool period of childhood. These children are often referred to as having "one cold after another." The highest incidence of nose and throat surgery prior to admission occurs in this group. The results are usually reported as unsatisfactory. The scratch or pressure-puncture skin tests are not very helpful. Intracutaneous testing is strongly indicated in this disorder. In the absence of positive cutaneous tests, the response to trial or elimination diets is most encouraging. Of all the allergic diseases, allergic coryza requires the most thorough elimination of offending foods from the diet, or irritating inhalants from the environment in order to obtain improvement. Food sensitivity producing allergic coryza may be replaced by inhalant sensitivity. Then asthma can appear as an associated allergic disorder.

Hay fever is an allergic disorder which appears earlier in life than the lower age limit set by many physicians. The onset in many of the cases is in the preschool period. Bronchial asthma becomes in children an important associated allergic disorder. Cutaneous testing is very satisfactory. Hyposensitization or desensitization gives encouraging results.

In Table IV. is condensed all the data obtained from a thorough review of the cases who were admitted to the clinic with a diagnosis of bronchial asthma. Hereditary tendency is very strong in asthma. Here is an allergic disease in which there is a high incidence of bilateral hereditary influence with a corresponding early onset of symptoms in the off-springs. One-fifth of the cases start in infancy and about one-half have their origin in the preschool period of childhood. Eczema is a common forerunner of asthma. The so-called "false positive food tests" which are frequently found in some allergic diseases, especially bronchial asthma, are closely related to a history of infantile eczema. Those children who have had eczema, tend to have positive cutaneous reactions to the ingestants, and these positive food tests are of little or no clinical value. More studies are necessary in order to make this observation an unquestionable factor and a time-saving measure in the interpretation of allergy skin tests and the outlining of the treatment of bronchial asthma.

The earlier the asthma manifests itself, the more likely the child is to develop concomitant allergic conditions. Individuals from strongly allergic families are somewhat more prone to the development of concomitant allergic conditions. In infancy and early childhood, the food allergens are very important, and in the latter part of the preschool period the foods and inhalants (animal emanations) are of equal importance. There is then an increasing sensitivity to the inhalants during the school years. The pollens become very important at puberty. Food sensitivity in early life is often followed in the same individual by sensitivity to inhalants which may prolong the asthma over a long period of time. House dust is becoming more and more important as an allergen. Recent studies tend to show that the potent substance in house dust is produced in the process of the aging of cotton. Secondary causes such as street dust, smoke, cold air play an important part in asthma of long duration. Iodides are effective in treatment although the so-called rhinitis occasionally found in association with asthma may be a reaction to the iodides if this form of treatment is being used. Calcium therapy has been very discouraging.

Although quite a number of the asthmatic children had large tonsils, only a small number were permitted to have them removed. In some instances, the asthma improved, in other cases, it became worse. It has therefore been suggested that the removal of tonsils and adenoids in allergic children should never be performed until the allergic investigations have been thoroughly carried out and the allergic symptoms well under control. If there is no urgent reason for the removal of the tonsils and adenoids, and they do not appear to be definitely infected, the operative procedure should be postponed pending the results of allergic treatment.

A review of the cases or urticaria and gastrointestinal allergy is presented in Tables V. and VI. The two allergic disorders have many things in common. The females predominate in both diseases. The family histories are more often negative than positive. The cutaneous tests indicate specific sensitivity in only a small number of patients. The intradermal tests may be tried. Trial or elimination diets are of greatest help although the results are not consistent. Acute infections are often the precipitating cause although food sensitivity appears to be the most common underlying cause.

SUMMARY AND CONCLUSIONS

1. A clinical review of the study made and the

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treatment carried out in 373 children with allergic disorders is presented.

2. The allergic diseases encountered are eczema, allergic coryza, hay fever, bronchial asthma, urticaria and gastro-intestinal allergy. They belong to that section of a newer classification of allergy entitled natural or atopic hypersensitiveness characterized by a strong hereditary tendency.

3. Our experience in the care of the allergic children indicates that a large number of cases can receive satisfactory relief. In obtaining this result, no elaborate methods of diagnosis are necessary, but instead a few rather simple procedures should be followed. All are considered of equal importance and are as follows:

(a) A very complete history.
(b) Cutaneous tests.
(c) Elimination or trial diets.

4. Treatment involves the thorough removal of the offending foods from the diet, or the irritating inhalants from the child's environment. Pollen allergy responds very well to proper and careful desensitization.

5. A small number of patients require surgical treatment in order to obtain relief.

6. The success depends upon the avoidance of all haste in the diagnosis and treatment. Delays in relieving the child are often necessary because histories must be retaken, cutaneous tests repeated and trial diets rearranged. A rather exhaustive search should be conducted for the offending allergen or allergens, and an effort should be made to avoid placing the patient on some form of drug therapy, thereby dismissing the search.

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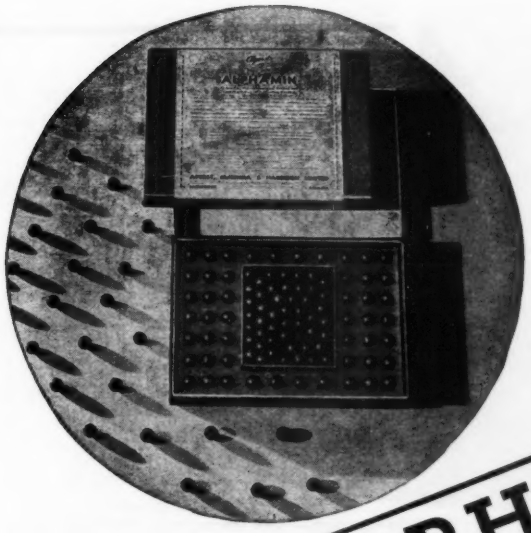

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